

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 07/28/2014	
NAME OF PROVIDER OR SUPPLIER COUNTRY CHARM VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 7212 US HWY 31 S INDIANAPOLIS, IN 46227			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
R000000	<p>This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00152777.</p> <p>Complaint IN00152777 - Substantiated. State residential deficiencies related to the allegations are cited at R0052 and R0090.</p> <p>Survey dates: July 23, 24, 25, and 28, 2014</p> <p>Facility number: 003283 Provider number: 003283 AIM number: N/A</p> <p>Survey team: Karyn Homan, RN-TC Patsy Allen, SW Dorothy Plummer, RN Marsha Smith, RN (7/23/2014)</p> <p>Census bed type: Residential: 53 Total: 53</p> <p>Census payor type: Medicaid: 34 Other: 19 Total: 53</p> <p>Residential sample: 8</p>		R000000				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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R000052	<p>These state residential findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on August 04, 2014; by Kimberly Perigo, RN.</p> <p>410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion.</p> <p>Based on interview and record review, the facility failed to ensure a resident was free from physical abuse in that the arm of a resident was grabbed by a staff member for 1 of 8 residents reviewed for an abuse allegation. (Resident #B)</p> <p>Findings include:</p> <p>The clinical record of Resident #B was reviewed on 7/23/14 at 1:05 p.m. Diagnoses included, but were not limited to, hypertension, Alzheimer's disease, depression, and blindness in the left eye.</p> <p>During an interview with Resident #B on</p>		R000052	<p>PLAN OF CORRECTION/COUNTRY CHARM VILLAGE This plan of correction is submitted as required under either or both State and Federal Law. The submission of this plan of correction on 8/16/2014 does not constitute an admission of fault of liability to the government entity of any third party, on the part of Country Charm Village, as to the accuracy of the surveyors' findings of the conclusions drawn therefrom. Submission of this plan of correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity</p>		08/31/2014	

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	<p>7/24/14 at 1:35 p.m., Resident #B indicated an employee had, "grabbed my arm hard" while the resident was attempting to help the employee. Resident #B indicated the employee said something to the resident as well, but could not remember exactly what was said. Resident #B indicated the incident, "hurt my feelings" and the resident returned to the resident's apartment after the incident. Resident #B indicated another staff member was present when the incident happened and 2 staff members had checked on the resident shortly after the incident. Resident #B was reluctant to report the incident, "Because I love living here and do not want to have to move."</p> <p>During an interview with the Corporate Executive Director (CED) and the Director of Nursing (DoN) on 7/24/14 at 3:00 p.m., the CED indicated the facility was in the process of investigating an incident/allegation of physical abuse involving Resident #B. The CED indicated a family member of Resident #B had faxed a concern to the facility regarding an incident with the Activity Director (AD) and Resident #B. The CED indicated the facility had a new Executive Director (ED) and the ED had initiated the investigation and filed a report when the fax was received on</p>		<p>regarding the deficiency cited are correctly applied. Any changes to the communities policies and procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 47 of the Federal Rules of Evidence and any corresponding state rules of civil procedure should be inadmissible in any proceeding on that basis and the community reserves the right to object to the admission of this statement of deficiency or the plan of correction under any other theory of law. The community submits this plan of correction with the intention that it is inadmissible by any third party in any civil or criminal action against the community or any employee, agent, officer, director, attorney, or shareholder of the community or affiliated companies. R 052 – Residents' Rights - Offense 1. The corrective action(s) that has been accomplished for Resident B was employee identified by Resident B is no longer employed at Country Charm Village. 2. The facility reviewed each resident's record and determined all residents could be affected by the alleged deficient practice and all employees were trained how to take preventative measures against similar actions in dealing with their</p>				

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	<p>7/21/14. The CED indicated the AD was suspended on 7/21/14, pending the results of the investigation.</p> <p>During the interview on 7/24/14 at 3:00 p.m., the DoN indicated Resident Assistant (RA) #4 had reported an incident to her on 7/1/14, that involved the AD and Resident #B. The DoN indicated RA #4 had informed her of Resident #B becoming upset, because the AD had grabbed the arm of the resident. The DoN indicated Resident #B was upset about the incident, but had no visible injuries. The DoN indicated she had checked on Resident #B and then had informed the ED of the incident. The DoN indicated she did not think the former ED had reported the incident to the Indiana State Board of Health (ISDH).</p> <p>During an interview with the CED on 7/25/14 at 3:40 p.m., the CED indicated he had spoken with the former ED regarding the incident with Resident #B and the former ED indicated the incident had been previously investigated and was determined not to have been a situation involving abuse and a report was not filed with ISDH. The CED indicated the file containing the investigation could not be located, but was able to find a signed statement from RA #3 who was present</p>		<p>emotions when caring for residents and also trained on abuse. 3. The measures that will be put into place and the systemic changes the facility will make to ensure that the deficient practice does not recur include the Executive Director or designee shall provide upon hire, a new hire orientation that all employees are knowledgeable or resident's rights, including physical, verbal, mental and sexual abuse. Staff shall be in-serviced on the definitions of neglect and abuse, including the responsibility to report any issues immediately to the Executive Director, DON, or department head. A check-off form shall be utilized to ensure all required items of orientation are completed. It is the policy of the facility to report any such suspected allegations immediately (within 24 hours) to the ISDOH, suspend alleged employee pending investigation, begin investigation, and provide a follow up report to ISDOH within (5) days. The Executive Director shall ensure the timely reporting and follow up of all reportable incidents. 4. The corrective action will be monitored by the Executive Director, Business Office Manager or designee will be</p>				

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	<p>at the time of the incident. The CED provided a copy of the handwritten statement dated 7/1/14. In the statement, RA #3 indicated the AD was observed grabbing the forearm of Resident #B and pulling Resident #B towards the door. RA #3 indicated Resident #B told the AD not to touch the resident and then Resident #B left the room. RA #3 then reported the incident to RA #4. The statement indicated RA #3 and RA #4 checked on the resident, and Resident #B showed the staff how the AD had grabbed the arm of the resident.</p> <p>During an interview with RA #4 on 7/28/14 at 1:45 p.m., RA #4 indicated RA #3 had reported an incident involving Resident #B and the AD to her on 7/1/14. RA #4 indicated when she and RA #3 checked on the resident shortly after the incident, Resident #B reported to her that the AD had grabbed the arm of the resident. RA #4 indicated she then reported the information to the DoN.</p> <p>Multiple attempts to contact RA #3 were unsuccessful. RA #3 was hired on 6/18/14. As of 7/28/14, the employee file for RA #3 lacked documentation of training for abuse prevention or reporting.</p> <p>On 7/28/14 at 10:10 a.m., the ED</p>		<p>responsible for monitoring the timely completion of orientation.</p> <p>5 To ensure continued compliance an ongoing annual in service will be conducted by the Ombudsman and over seen by the Administrator 6.</p> <p>The date the systemic changes will be completed by is August 31, 2014.</p>				

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R000090	<p>provided copies of hours and days worked for the AD. A review of the hours worked indicated the AD worked 7/1, 7/2, 7/3, 7/7, 7/8, 7/9, 7/11, 7/12, 7/13, 7/14, 7/15, 7/17, 7/18, and 7/21/14. The timesheet indicated the AD clocked out 2:27 p.m., 4 hours after the fax was received from the family member of Resident #B indicating the AD had physically abused the resident.</p> <p>On 7/23/14 at 11:10 a.m., the Marketing Director provided a copy of an undated Resident's Rights Residential Care Facility and indicated the policy was the one currently used by the facility. Page x of the document indicated, "... (v) Residents have the right to be free from: ... (2) physical abuse; (3) mental abuse...."</p> <p>This state residential tag relates to Complaint IN00152777.</p> <p>410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual</p>						

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	<p>occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:</p> <p>(A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents.</p> <p>If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.</p> <p>(2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.</p> <p>(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.</p> <p>(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:</p> <p>(A) employee's full name; and (B) dates and hours worked during the past twelve (12) months.</p> <p>(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.</p> <p>(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request</p>						

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	<p>Based on interview and record review, the facility failed to ensure the division was notified within 24 hours of becoming aware of a reported staff to resident physical abuse occurrence for 1 of 8 residents reviewed for abuse. (Resident #B)</p> <p>Findings include:</p> <p>The clinical record of Resident #B was reviewed on 7/23/14, at 1:05 p.m. Diagnoses included, but were not limited to, hypertension, Alzheimer's disease, depression, and blindness in the left eye.</p> <p>During an interview with Resident #B on 7/24/14 at 1:35 p.m., Resident #B indicated an employee had, "grabbed my arm hard" while the resident was attempting to help the employee. Resident #B indicated the employee said something to the resident as well, but could not remember exactly what was said. Resident #B indicated the incident, "hurt my feelings" and the resident returned to the resident's apartment. Resident #B indicated another staff member was present when the incident happened and 2 staff members had checked on the resident shortly after the incident.</p> <p>During an interview with the Corporate</p>	R000090	<p>R 090 – Administration and Management - Deficiency 1. The corrective action(s) that has been accomplished for Resident B was <i>employee identified by Resident B is no longer employed at Country Charm Village. Executive Director followed up with Resident B to determine if any further action was required. Resident B stated she is fine as long as the identified employee was not going to assist her anymore.</i> 2. The facility reviewed each resident's record and determined all residents could be affected by the alleged deficient practice and all employees were trained how report similar incidents to ISDOH and the Executive Director designated the DON to make such reports in her absence. 3. The measures that will be put into place and the systemic changes the facility will make to ensure that the deficient practice does not recur include the Executive Director self-study and discussions with her management team on the reporting requirements and procedures identified in this deficiency. The Executive Director, after completing her study and discussions with the management team shall in-service and re-educate all staff regarding the reporting requirements associated with physical, sexual and mental abuse. This topic will also be</p>		08/31/2014		

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	<p>Executive Director (CED) and the Director of Nursing (DoN) on 7/24/14 at 3:00 p.m., the CED indicated the facility was in the process of investigating an incident/allegation of physical abuse involving Resident #B. The CED indicated a family member of Resident #B had faxed a concern to the facility regarding an incident with the Activity Director and Resident #B. The CED indicated the facility had a new Executive Director (ED) and the ED had initiated the investigation and filed a report when the fax was received on 7/21/14.</p> <p>During the interview on 7/24/14 at 3:00 p.m., the DoN indicated Resident Assistant (RA) #4 had reported an incident to her on 7/1/14, that involved the AD and Resident #B. The DoN indicated RA #4 had informed her of Resident #B becoming upset, because the AD had grabbed the arm of the resident. The DoN indicated Resident #B was upset about the incident, but had no visible injuries. The DoN indicated she had checked on Resident #B and then had informed the ED of the incident. The DoN indicated she did not think the former ED had reported the incident to the Indiana State Board of Health (ISDH).</p> <p>During an interview with the CED on</p>		<p>covered as part of new employee orientation. This shall include the requirements to initiate the investigation and provide the ISDOH with the follow up report of findings within five (5) days thereof. 4. The Executive Director shall monitor daily all incident reports to ensure the reporting is made to the State on a timely basis. In her absence the DON shall monitor the incident reports.</p> <p>5 To ensure continued compliance an ongoing annual in service will be conducted by the Ombudsman and overseen by the Administrator. 6 . The date the systemic changes will be completed by is August 31, 2014</p>				

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	<p>7/25/14 at 3:40 p.m., the CED indicated he had spoken with the former ED regarding the incident with Resident #B, and the former ED indicated the incident had been previously investigated and was determined not to have been a situation involving abuse and a report was not filed with ISDH. The CED indicated the file containing the investigation could not be located, but was able to find a signed statement from RA #3 who was present at the time of the incident. The CED provided a copy of the handwritten statement dated 7/1/14. In the statement, RA #3 indicated the AD was observed grabbing the forearm of Resident #B and pulling Resident #B towards the door. RA #3 indicated Resident #B told the AD not to touch the resident and then Resident #B left the room. RA #3 then reported the incident to RA #4. The statement indicated RA #3 and RA #4 checked on the resident, and Resident #B showed the staff how the AD had grabbed the arm of the resident.</p> <p>During an interview with RA #4 on 7/28/14 at 1:45 p.m., RA #4 indicated RA #3 had reported an incident involving Resident #B and the AD to her on 7/1/14. RA #4 indicated when she and RA #3 checked on the resident shortly after the incident, Resident #B reported to her that the AD had grabbed the arm of the</p>						

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	<p>resident. RA #4 indicated she then reported the information to the DoN.</p> <p>Multiple attempts to contact RA #3 were unsuccessful. RA #3 was hired on 6/18/14. As of 7/28/14, the employee file for RA #3 lacked documentation of training for abuse prevention or reporting.</p> <p>On 7/28/14 at 10:10 a.m., the ED provided copies of hours and days worked for the AD. A review of the hours worked indicated the AD worked 7/1, 7/2, 7/3, 7/7, 7/8, 7/9, 7/11, 7/12, 7/13, 7/14, 7/15, 7/17, 7/18, and 7/21/14. The timesheet indicated the AD clocked out 2:27 p.m., 4 hours after the fax was received from the family member of Resident #B indicating the AD had physically abused the resident.</p> <p>On 7/23/14 at 11:10 a.m., the Marketing Director provided a copy of an undated Resident's Rights Residential Care Facility and indicated the policy was the one currently used by the facility. Page x of the document indicated, "... (v) Residents have the right to be free from: ... (2) physical abuse; (3) mental abuse..."</p> <p>This state residential tag relates to Complaint IN00152777.</p>						

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R000092	<p>410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift. This had the potential to affect 53 residents who reside in the facility. Findings include:</p>		R000092	<p>R 092 – Administration and Management - Noncompliance 1. All residents were allegedly affected by this deficiency and the corrective action to be accomplished is described below. 2 and 3. To ensure all residents are no longer at risk to be affected by this deficiency and the measures that will be put in</p>		08/31/2014	

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	<p>Review of Country Charm Village Management Fire Drill documentation on 7/23/14 at 11:45 a.m., the facility lacked documentation of an implemented fire drill for third shift (nights) for the second quarter of 2014. They lacked the documentation of an implemented second shift (evening) fire drill for first quarter and second quarter of 2014. They lacked the documentation of an implemented fire drill for first shift (day) for the first quarter of 2014.</p> <p>Interview with Administrator on 7/28/14 at 1:50 p.m., indicated that they did not have documentation of the missing fire drills or where they had tried to set up a fire drill with the local fire department. He continued to indicate, the facility had provided all the documentation on the fire drills they had.</p> <p>In an interview with the Corporate Executive Director on 7/25/14 at 11:25 a.m., indicated that the facility could not locate a fire drill policy.</p> <p>On 7/25/14 at 11:25 a.m., the Corporate Executive Director provided the Fire Drill Procedure and indicated this procedure was the one currently being used by the facility. The fire drill procedure indicated at the end of a fire drill to, "... Complete the Fire Drill</p>				<p>place and the systemic changes the facility will make to ensure that the deficient practice does not recur include the Executive Director, in coordination with the facility maintenance director, creating a policy and an in-service calendar to insure the timely completion of facility fire drills and disaster preparedness. The Executive Director along with the maintenance director shall review, update, and monitor the facility disaster preparedness plan, including making contact with the local fire department to conduct to not only the required fire drills therein, but to review the role of the fire department and other para-medical agencies the response time and instructions for other potential disasters. Quarterly fire drills will be conducted on each shift and include a schedule to ensure a quarterly fire drill 4. The Executive Director shall monitor monthly for compliance. A quarterly fire drill was completed 7/31/14 for residents and staff of each shift, and the maintenance director is instructed to perform at least twelve (12) drills each year, including the recording of training performed, and the documented names and signatures of staff present. 5. The date the systemic changes will be completed by is August 31, 2014.</p>		

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R000116	<p>Records Sheet, remember to get all staff participants signatures. Once forms are complete give to Executive Director for signature."</p> <p>410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on record review and interview, the facility failed to check references in that 4 of 9 employee files reviewed lacked documentation for references. (Certified Nurse Aide # 9, #20, & #34) (License Nurse # 41)</p> <p>Findings include:</p> <p>Review of employee files on 7/24/14 at 10:00 a.m., 4 of 9 employees files reviewed lacked documentation of references.</p> <p>1.) Certified Nurse Aide # 09, hire date of 06/18/14, had no documentation of references being completed.</p>		R000116	<p>R 116 – Personnel - Noncompliance</p> <p>1. The Community completed the reference checks on Certified Nurse Aides 9, 20 and 34 and License Nurse 41, 2. The Executive Director and facility business office personnel shall review the facility new hire check list of requirements, including the completion of all prospective employee reference checks for all current employees to ensure that all reference checks are completed and documented and available in the employee personnel file. 3. The measures that will be put into place and the systemic changes the facility will make to ensure that the deficient practice does</p>		08/31/2014	

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R000119	<p>2.) Certified Nurse Aide # 20, hire date of 05/19/14, had no documentation of references being completed.</p> <p>3.) License Nurse # 34, hire date of 06/03/14, had no documentation of references being completed.</p> <p>4.) License Nurse # 41, hire date of 07/03/14, had no documentation of references being completed.</p> <p>Interview with the Administrator on 07/28/14 at 1:50 p.m., indicated the facility had provided all the documentation they had. They were unable to locate the facility's policy and procedure for completing employee files.</p> <p>410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- Personnel - Noncompliance (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations:</p>			<p>not recur is the business office manager has been in-serviced with the new employee hire check list of requirements before their start of work date. Department heads are instructed and a policy drafted that any potential new hire is not eligible to work or begin a work shift until all new hire personnel requirements are complete. 4. The Executive Director shall monitor monthly for compliance. 5. The date the systemic changes will be completed by is August 31, 2014</p>			

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	<p>(A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation.</p> <p>Based on interview and record review, the facility failed to provide documentation of initial orientation for 4 of 9 employee files reviewed in that prior to working independently the employee's file lacked documentation to indicated having received orientation which included: a review of resident's rights, general job description and abuse training. (Certified Nurse Aide #9, #20, & #34) (License Nurse # 41)</p> <p>Findings include:</p>	R000119	<p>R 119 – Personnel - Noncompliance 1. Employees 9, 20, 34, and 41 not receiving initial orientation, a review of resident's rights, general job description and abuse training before working with residents received training and orientation. The policy for such was made available to these employees and put in a place where access is readily available during a survey and for all management and employees. 2. The Executive Director, along with the Business Office Director,</p>		08/31/2014		

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	<p>Review of employee files on 7/24/14 at 10:00 a.m., indicated 4 of 9 employees did not receive initial orientation, a review of resident's rights, general job description and abuse training before employees began working with residents.</p> <p>1.) Certified Nurse Aide #09, hire date of 06/18/14, had no documentation of receiving initial orientation, a review of resident's rights, general job description and abuse training. Review of current CNA Schedule, July 13- July 26,2014; indicated CNA #09 remained actively working with residents.</p> <p>2.) Certified Nurse Aide #20, hire date of 05/19/14, had no documentation of receiving initial orientation, a review of resident's rights, general job description and abuse training. Review of current CNA Schedule, July 13- July 26, 2014; indicated CNA #20 remained actively working with residents</p> <p>3.) Licensed Nurse #34, hire date of 06/03/14, had no documentation of receiving initial orientation, a review of resident's rights, general job description and abuse training. Review of current Nurse/ QMA Schedule, July 13- July 26, 2014; indicated LPN #34 remained actively working with residents</p>		<p>and specific department heads, shall review all existing personnel files to insure that any current employee who has not completed the required orientation, nor has a signed job description, completes therein. 3. The Executive Director shall create a new hire Orientation program to provide and insure that all new hire employees are aware, informed, and knowledgeable regarding many of the facilities rules, policies, and guidelines, including residents' rights, fire drills, disaster preparedness, and resident abuse training. The Executive or designee shall conduct an orientation with all new hires prior to working independently. The orientation shall include: review of the employee handbook and facility policy and applicable procedures, first aid and emergency procedures, fire and disaster preparedness, evacuation procedures; HIPPA regulations, and resident rights and privacy, and other information relevant to the position of the new hire. This shall include instruction for a specialized population to include aging, memory, and dementia. The Executive Director shall review the new orientation worksheet to insure completeness and preparedness prior to the new hire working independently. The Executive, along with the department heads, will insure that each new</p>				

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R000121	<p>4.) License Nurse #41, hire date of 07/03/14, had no documentation of receiving initial orientation, a review of resident's rights, general job description and abuse training. Review of current Nurse/ QMA Schedule, July 13- July 26, 2014; indicated LPN #41 remained actively working with residents</p> <p>Interview with the Administrator on 07/28/14 at 1:50 p.m., indicated the facility had provided all the documentation they had. They were unable to locate the facility's policy and procedure for completing employee files.</p> <p>410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read,</p>			<p>employee receives and understands the duties and responsibilities of their job/employment description; reads and signs receipt thereof, and completes the orientation program prior to the start of work and or working independently. The Executive Director shall monitor monthly for compliance. 4. The Executive Director shall monitor compliance. 5. The date the systemic changes will be completed by is August 31, 2014.</p>			

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	<p>and by whom administered. The facility must assure the following:</p> <p>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.</p> <p>(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.</p> <p>Based on interview and record review, the facility failed to ensure 5 of 9 employees files reviewed received a completed Health Screening prior to having contact with the residents. (Certified Nurse Aide #9, #20, & #34) (License Nurse #41) (Dietary aide #12)</p>	R000121	<p>R 121 – Personnel - Noncompliance</p> <p>1. Employees 9, 20, 34, 41, and 12 have had their health screens completed.</p>		08/31/2014		

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	<p>Findings include:</p> <p>Review of employee files on 7/24/14 at 10:00 a.m., indicated 5 of 9 employees did not have a health screening done. The facility failed to acquire a completed health screening before employees began working with residents.</p> <p>1.) Certified Nurse Aide #09, hire date of 06/18/14, had no documentation of a health screen. Review of current CNA Schedule, July 13 - July 26, 2014; indicated CNA #09 remained actively working.</p> <p>2.) Certified Nurse Aide #20, hire date of 05/19/14, had no documentation of a health screen. Review of current CNA Schedule, July 13 - July 26, 2014; indicated CNA #20 remained actively working with residents.</p> <p>3.) License Nurse #34, hire date of 06/03/14, had no documentation of a health screen. Review of current Nurse/QMA Schedule, July 13 - July 26, 2014; indicated LPN #34 remained actively working.</p> <p>4.) License Nurse #41, hire date of 07/03/14, had no documentation of a health screen. Review of current Nurse/QMA Schedule, July 13 - July 26,</p>				<p>2. The Business Office Director shall review all current employee personnel files to determine any employee who is missing the required health assessment screen and tuberculin skin test. Nursing department shall initiate any missing skin test, and record in the respective employee file.</p> <p>3. A new hire policy was created that requires the proper screening to include the following: TB testing, background check, excluded party check, physical health approval, drug test prior to hire and resident contact, and sex offender check. The Business Office Director shall utilize the new employee hire requirements checklist to monitor and record all new hire employee documents, including the checklist for the signature of the Executive Director for approval, prior to start of work date.</p> <p>4. The Director of Nursing shall be responsible for the monitoring the completion of all new hire health screens.</p> <p>5. The date the systemic changes will be completed by is August 31, 2014.</p>		

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R000144	<p>2014; indicated LPN #41 remained actively working with residents.</p> <p>5.) Dietary aide #12, hire date of 06/23/14, had no documentation of a health screen. Review of current dietary work schedule, July 13 - July 26, 2014; indicated Dietary Aide #12 remained actively working with residents.</p> <p>Interview with the Administrator on 07/28/14 at 1:50 p.m., indicated the facility had provided all the documentation they had. It was not done right in the past, but they were moving forward and doing it right.</p> <p>410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents.</p> <p>Based on observation and interview, the facility failed to provide housekeeping services necessary to maintain a sanitary, orderly, and comfortable interior. This had the potential to affect 53 of 53 residents residing in the facility.</p> <p>Findings included:</p>	R000144	<p>R 144 – Sanitation and Safety Standards - Deficiency</p> <p>1. All residents were allegedly affected by this deficiency and the corrective action to be accomplished is described below. In addition, the Executive</p>		09/10/2014		

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	<p>On 7-23-14 at 2:25 p.m., the following was observed:</p> <p>1.) Near resident room 24 there was a reddish brown substance dried on the wall and baseboard.</p> <p>2.) Through out the facility hallways, handrails are located on the walls. The handrails had an approximate 2 inch groove between the outer surface and the wall. The grooves of the handrails were severely littered with dirt, trash, debris, deceased insects, food particles, and half a medication capsule.</p> <p>3.) In the resident laundry room an ironing board had brown splattered spill stains from the middle of the board to the end. In the entrance of the laundry room, there were splatter and spill stains on the wall, cobwebs behind the ironing boards, and the walls throughout the laundry room had areas the drywall was damaged, exposed, and had nicked and gouged areas. The wallpaper boarder close to the ceiling was detached and frayed around the entire perimeter of the room. The hardware attaching a detergent dispenser to the wall was mounted, but the actual dispenser was gone. The hand sink that the eyewash station was located at lacked any type of eyewash solution. The pipes located beneath the hand sink had an</p>		<p>Director shall instruct housekeeping that soiled area near resident room # 24 is thoroughly cleaned. The Executive Director shall monitor on a weekly basis to ensure compliance. The Executive Director has instructed housekeeping to perform a deep cleaning of the hallway handrails, areas behind thereof, and to maintain a part of the regular cleaning schedule.</p> <p>The Executive Director has also scheduled the resident laundry for a complete cleaning of the floors, pipes, lights, and sprinkler heads, along with the removal of wallpaper, and painting for 8/12/14. This shall include the purchasing of a new ironing board and or cover.</p> <p>The corridor wall near room #45 and extending the balance of the hallway thru resident room # 67 is scheduled for complete painting the week of 8/11/14. This includes the cleaning of cobwebs, and other dirt and debris. This includes cleaning the door jamb near resident room #47. The vent also near the mechanical room shall be cleaned 8/11/14.</p>				

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	<p>accumulation of dirt, dust, and debris. The floor tiles under the counter were loose and raised. The expanse of the floor was covered with dust, dirt, and debris. The sprinkler head was covered with a white substance which appeared to be a dryer sheet. The sprinkler head was pulled away from the wall. A trash can was overflowing with trash. The trash had began to accumulated on the floor surrounding the trash can.</p> <p>4.) In the corridor next to resident room 45 the wallpaper was missing on both sides of the door.</p> <p>5.) There were cobwebs around the emergency exit door handle at the end of the corridor.</p> <p>6.) The door jam near resident room 47 had an accumulation of dirt and debris.</p> <p>7.) The vent located near the mechanical room had an accumulation of dust, dirt, and debris.</p> <p>8.) In resident room 77 the carpet was soiled and stained.</p> <p>9) The ceiling fan blades in the activity room had a black substance, thick accumulation of dirt, and dust.</p>		<p>The carpet in resident room # 77 shall be deep cleaned the week of 8/18/14. New carpet shall be purchased and installed if the E.D. determines that the carpet does not come clean. Housekeeping and Executive Director shall monitor for cleanness thereafter. Also, the fans and light fixtures in activity room were cleaned 7/31/14. Housekeeping has also been instructed to clean and sanitize all community water fountains. Because of the age of the physical fountain equipment; if cannot be completely clean to the Executive Director satisfaction, the actual drinking fountains shall be removed, the walls repaired and repainted.</p> <p>2 and 3. To ensure all residents are no longer at risk to be affected by this deficiency and the measures that will be put in place and the systemic changes the facility will make to ensure that the deficient practice does not recur include the Executive Director, along with the Maintenance and Housekeeping director have created daily assignment sheets to review, monitor and evaluate certain facility cleaning, sanitation and safety issues. Housekeeping shall be provided with in-service for resident room cleaning and resident common areas.</p>				

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	<p>10) The water drinking fountain located near the resident living room was cover with a accumulation of a white substance and blue/green substance on the water spout and top of the fountain.</p> <p>11) The water drinking fountain located near the resident room 54 was cover with a accumulation of a white substance and blue/green substance on the water spout and top of the fountain.</p> <p>12) The water drinking fountain located near the resident room 58 was cover with a accumulation of a white substance and blue/green substance on the water spout and top of the fountain.</p> <p>13) The water drinking fountain located near the resident room 6 was cover with a accumulation of a white substance and blue/green substance on the water spout and top of the fountain.</p>		<p>Housekeeping is instructed which items to clean, how to clean, chemicals appropriate to use to insure proper cleaning results. Housekeeping has also been in-serviced on all the deficient practices as presented in the alleged deficiency and addressed above in number 1. Daily cleaning assignment sheet are provided and returned to the Executive Director for daily inspection and compliance which shall include the identified items in the deficiency as well as items observed during the Executive Director's daily rounds.</p> <p>4. The Executive Director or designee shall make rounds daily to monitor the cleanliness of the building common and community areas, sample 5 resident rooms daily, and insure that housekeeping and maintenance issues are addressed, monitored and resolved before the end of shift. The Executive Director or designee shall review daily cleaning assignment sheets for compliance.</p> <p>5. The date the systemic changes will be completed by is September 10, 2014.</p>				

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R000148	<p>410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected.</p> <p>Based on record review and interview, the facility failed to ensure the building was free of hazards that may affect the health of residents or the public and the heating and ventilating systems were inspected yearly. This had the potential to affect 53 residents who reside in the facility.</p> <p>Findings include:</p> <p>During environmental tour on 7/23/14 at 2:25 p.m. the following was observed:</p> <p>1a) In the living room on the secured unit, a drawer of end table(assessable to</p>	R000148	<p>R 148 – Sanitation and Safety Standards - Deficiency 1 and 2. All residents were allegedly affected by this deficiency and the corrective action to be accomplished will be the Executive Director and Maintenance Director have (8/4/14) re-keyed, locked and secured the common are storage closed. Each resident room shall be re-keyed with locked and secured storage cabinets for personal items, and safe and secure from other residents. 3. The Housekeeping and Other specific and related departments shall receive an in-service regarding chemicals used, and the appropriate and safe way to</p>		08/15/2014		

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	<p>residents) was partially open. There was 1 bottle of hand sanitizer with a warning label, "flammable, keep out of reach of children, do not use in eye, if swallowed seek medical help/ contact poison control."</p> <p>1b) There were also, three 1.8 ounces cans of aerosol spray with a warning label, "flammable, keep out of reach of children, may cause eye irritation, if inhaled may be harmful, or fatal. Keep away from sunlight, remove cap and install only in automatic dispenser units which is positioned so that the concentrated spray will not hit people, animals, food, drinks, food processing surface, keep can at least 8 ft away from exposed food."</p> <p>On 7/23/14 Housekeeping Director indicated that the facility no longer used aerosol spray dispensers in the secured unit.</p> <p>1c) In the living room in the secured unit, on the shelf behind the entrance door was a half full can of red bull and an empty cup, on the shelf with books and games were hand held garden tools (a shovel and three prong rake). Also located on the shelf were two 16 oz. bottles of hand lotion with warning label, "keep out of reach of children."</p>		<p>use, store, and protect chemicals and cleaning agents in safeguarding the residents from obtaining, touching or swallowing. This in service will be conducted upon hire of new employees with documentation placed in the employee file. The Executive Director shall instruct that the Maintenance Director work with an outside HVAC contractor and vendor to initiate and perform an annual systems and equipment inspection. This was completed the week of 8/4/14. The Executive Director and Maintenance Director shall create a preventative maintenance schedule to insure that the equipment and fixtures are properly serviced and maintained. 4. The Executive Director shall review and monitor monthly for compliance. 5. The date the systemic changes will be completed by is August 15, 2014.</p>				

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R000154	<p>On 7/23/14 at 4:00 p.m., Director of Nursing indicated, the aforementioned items had the potential to affect 7 ambulatory residents of 9 residents utilizing the living room and residing on the secure Alzheimer/Dementia unit.</p> <p>2) On 7/28/14 at 1:05 p.m., an interview with Maintenance Director was conducted he indicated, that he could not find any documentation of the heating and ventilating system being inspected.</p> <p>On 7/28/14 at 1:50 p.m., the Administrator indicated, the documentation of the inspection of the heating and ventilating system could not be found.</p> <p>410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation and interview, the facility failed to keep all kitchens and</p>		R000154	<p>R 154 – Sanitation and Safety Standards - Deficiency 1, 2 and 3. All residents were</p>		08/31/2014	

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	<p>kitchen areas clean, maintained, and in good repair. This had the potential to affect 53 of 53 residents, who ate food prepared in the kitchen.</p> <p>Findings include:</p> <p>During sanitation tour with the Dietary Manager on 07-23-14 at 10:10 a.m., with the following observed:</p> <p>1) In the kitchen the floor drain located between the stove and steamer was soiled, had peeling/missing paint, and rusty.</p> <p>2) The ceiling vents located above the food preparation area, in dry food storage room, and over clean area of dishmachine, were soiled with accumulation of dirt and dust extending to the ceiling.</p> <p>3) The door frame going into the dish machine is soiled with dirt, stains, has scraped, peeling and missing paint.</p> <p>4) In the steam table room the area near the ice machine had accumulation of multiple color splatter/spill stains and gouged areas on the wall.</p> <p>5) Ceiling vents located over the refrigerator and the ice machine was</p>		<p>allegedly affected by this deficiency and the corrective action to be accomplished will be the Executive Director, Dietary Manager, Maintenance and Housekeeping shall create and review a schedule and assignment sheet to insure all equipment, floors and space with the dietary and serving areas are kept clean, neat and needed repairs resolved. The kitchen floor drain shall be cleaned and painted, the ceiling vents cleaned, the walls in the dietary serving area painted, and certain door frames within the kitchen area shall be painted. The respective departments shall work together to insure certain weekly, and monthly cleanings and maintenance. The Executive Director and Dietary manager shall create a preventive maintenance and cleaning schedule to insure work and serving spaces are clean, neat and orderly; including the identification of certain items and spaces in need of repair, maintenance or replacement.</p> <p>4. The Executive Director shall review and monitor monthly for compliance. 5. The date the systemic changes will be completed by August 31, 2014.</p>				

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R000214	<p>soiled with dirt/dust extending to the ceiling</p> <p>6) The floor drain cover located near the ice machine was soiled with dirt and debris, had peeling/missing paint, and rust.</p> <p>During an interview with the Dietary Manager she indicated she agreed with the above mentioned findings, but they had been without a maintenance director for about 3 months.</p> <p>410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident 's condition, or more often at the resident 's or facility 's request. A licensed nurse shall evaluate the nursing needs of the resident.</p> <p>Based on interview and record review, the facility failed to evaluate the needs of residents prior to admission and twice a year following admission for 8 of 8 residents reviewed. (Residents #A, #B, #C, #60, #61, #50, #46, and #18)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #B was</p>	R000214	<p>R 214 – Evaluation - Deficiency</p> <p>1. The corrective action for Residents A, B, C, 60, 61, 50, 46, and 18 was to ensure that going forward the assessments and evaluation of these residents needs are current and a careful review of their past records to ensure nothing is missed that may not be showing up in the current daily records. 2. The facility reviewed each resident's record and determined all</p>		09/15/2014		

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	<p>reviewed on 7/23/14 at 1:05 p.m. Diagnoses included, but were not limited to, hypertension, Alzheimer's disease, depression, and blindness in the left eye.</p> <p>Resident #B was admitted to the facility on 5/31/13. A functional evaluation was completed prior to admission. The next functional evaluation for Resident #B was completed on 7/21/14, 14 months after Resident #B was admitted to the facility.</p> <p>During an interview with the Director of Nursing (DoN) on 7/24/14 at 4:05 p.m., the DoN indicated the facility had identified multiple resident assessments and evaluations, which had not been completed in a timely manner. The DoN indicated she was in the process of completing evaluations for all of the residents.</p> <p>2. The clinical record of Resident #C was reviewed on 7/25/14 at 9:20 a.m. Diagnoses included, but were not limited to, congestive heart failure, high blood pressure, diabetes, and depression.</p> <p>Resident #C was admitted 3/1/10.</p> <p>Resident #C had a functional evaluation completed on 2/13/13. As of 7/28/14, a re-evaluation of functional status had not</p>		<p>residents could be affected by the alleged deficient practice The Executive Director and DON shall review the resident listing of current residents to insure that all assessments and evaluations are updated and current to meet the specific resident needs for care and services. This shall also include the assessment and evaluation of certain residents who may require a memory, fall, or gait assessment. 3. The measures that will be put into place and the systemic changes the facility will make to ensure that the deficient practice does not recur include the DON shall review and monitor daily nursing charting and communication logs to accurately identify services being provided, and determine appropriate changes to the service plans as warranted. The DON shall also create a resident list detailing assessment and evaluation dates; and dates for required review. The Executive Director and DON shall create a nursing QA compliance committee, and identify certain items on a quarterly basis to monitor and review and work with the Corporate Quality Assurance Director for consult as necessary. This shall include that the DON shall be responsible for completing a clinical record audit of all residents weekly for 4 weeks, then every other week for 8 weeks, then monthly 3 months. Results will be reported and</p>				

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	<p>been completed for Resident #C.</p> <p>During an interview with the Director of Nursing (DoN) on 7/24/14 at 4:05 p.m., the DoN indicated the facility had identified multiple resident assessments and evaluations which had not been completed in a timely manner. The DoN indicated she was in the process of completing evaluations for all of the residents.</p> <p>On 7/28/14 at 2:30 p.m., the DoN indicated Resident #C did not have a functional evaluation completed after 2/13/13.</p> <p>3. Resident #50's clinical record was reviewed on 7/23/2014 at 1:00 p.m. Diagnoses included, but were not limited to, dementia (mental disorder affecting memory, personality, and reasoning), hypertension (high blood pressure), and anorexia (loss of appetite).</p> <p>Resident #50 was admitted 3/10/2012.</p> <p>Assessment and Service Plan for Indiana Assisted Living Facility for Resident #50 was completed 3/15/2013.</p> <p>No documentation was found indicating a semi-annual evaluation had been completed for Resident #50, since 3/15/2013.</p>		<p>reviewed with the Executive Director and QA committee and further corrective actions as deemed necessary. 4. The Executive Director shall weekly and monthly review the nursing review date schedule to insure all assessments and evaluation are done timely and current. 5. The date the systemic changes will be completed by September 15, 2014.</p>				

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	<p>On 7/24/2014 at 10:51 a.m., the Director of Nursing (DoN) indicated, she was unable to locate an evaluation completed for Resident #50, since 3/15/2013.</p> <p>4. Resident #61's clinical record was reviewed on 7/23/2014 at 2:30 p.m. Diagnoses included, but were not limited to, dementia (mental disorder affecting memory, personality, and reasoning), diabetes (disorder causing irregular blood sugars), and hypertension (high blood pressure).</p> <p>Resident #61 was admitted 5/1/2011.</p> <p>Assessment and Service Plan for Indiana Assisted Living Facility for Resident #61 was completed 9/5/2013.</p> <p>No documentation was found indicating a semi-annual evaluation had been completed for Resident #61, since 9/5/2013.</p> <p>On 7/28/2014 at 11:40 a.m., the DoN indicated, she was unable to locate an evaluation completed for Resident #61, since 9/5/2013.</p> <p>5. Resident #60's clinical record was reviewed on 7/24/2014 at 9:10 a.m. Diagnoses included, but were not limited</p>						

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	<p>to, hypertension (high blood pressure), end stage renal failure (kidney failure), and anemia (low red blood cell count).</p> <p>Resident #60 was admitted 7/5/2012.</p> <p>Assessment and Service Plan for Indiana Assisted Living Facility for Resident #60 was completed 9/12/2013.</p> <p>No documentation was found indicating a semi-annual evaluation had been completed for Resident #60, since 9/12/2013.</p> <p>On 7/24/2014 at 1:45 p.m., the DoN indicated, she was unable to locate an evaluation completed for Resident #60, since 9/12/2013.</p> <p>6. Resident #46's clinical record was reviewed on 7/24/2014 at 11:30 a.m. Diagnoses included, but were not limited to, dementia (mental disorder affecting memory, personality, and reasoning), hypertension (high blood pressure), and Crohn's disease (inflammatory bowel disease).</p> <p>Resident #46 was admitted 3/5/2012.</p> <p>Assessment and Service Plan for Indiana Assisted Living Facility for Resident #46 was completed 3/25/2013.</p>						

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	<p>No documentation was found indicating a semi-annual evaluation had been completed for Resident #46, since 3/25/2013.</p> <p>On 7/28/2014 at 9:15 a.m., the DoN indicated, she was unable to locate an evaluation completed for Resident #46, since 3/25/2013.</p> <p>7. Resident #A's clinical record was reviewed on 7/24/2014 at 2:00 p.m. Diagnoses included, but were not limited to, cerebrovascular accident (blood flow stopped to the brain, causing brain cell death) with left sided hemiparesis (muscle weakness on one side of the body), hypertension (high blood pressure) and urge incontinence (strong sudden need to urinate due to bladder spasms).</p> <p>Resident #A was admitted 5/30/2012.</p> <p>Assessment and Service Plan for Indiana Assisted Living Facility for Resident #A was completed 4/25/2013.</p> <p>No documentation was found indicating a semi-annual evaluation had been completed for Resident #A, since 4/25/2013.</p> <p>On 7/28/2014 at 9:15 a.m., the DoN</p>						

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	<p>indicated, she was unable to locate an evaluation completed for Resident #A, since 4/25/2013.</p> <p>On 7/23/2014 at 5:00 p.m., the DoN indicated, the facility's policy is to complete an evaluation and service plan every three months.</p> <p>8. Resident #18's clinical record was reviewed on 7/25/2014 at 1:20 p.m. Diagnoses included, but were not limited to, hypertension (high blood pressure), cerebrovascular accident (blood flow to the brain is stopped, causing brain cell death), and pernicious anemia (decrease in red blood cells caused by abnormal absorption of vitamin B12).</p> <p>Resident #18 was admitted 6/30/2014.</p> <p>No documentation was found indicating a pre-admission evaluation was completed for Resident #18, prior to his admission to the facility.</p> <p>On 7/28/2014 at 9:15 a.m., the DoN indicated, she was unable to locate a pre-admission evaluation for Resident #18, prior to his admission on 6/30/2014. She continued to indicate, she had completed an evaluation of Resident #18 on 7/26/2014.</p>						

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R000217	<p>On 7/28/2014 at 9:00 a.m., the DoN provided an untitled section from Health Related Service Ops Manual, undated, and indicated the policy was currently used by the facility. The policy indicated, "... Service Planning and Coordination -Initial Resident assessments performed before move-in, in consultation with the Wellness Director as needed -Coordination of service planning process upon move-in, 30 day review post move-in and every 90 days thereafter or as significant changes occur ..."</p> <p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a</p>						

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	<p>copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on interview and record review, the facility failed to document services to be provided by the facility for 8 of 8 residents reviewed. (Residents #A, #B, #C, #60, #61, #50, #46 and #18)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #B was reviewed on 7/23/14 at 1:05 p.m. Diagnoses included, but were not limited to, hypertension, Alzheimer's disease, depression, and blindness in the left eye.</p> <p>Resident #B was admitted to the facility on 5/31/13. A functional evaluation was completed prior to admission. Resident #B did not have a service plan developed until 7/21/14, 14 months after Resident #B was admitted to the facility.</p> <p>During an interview with the Director of Nursing (DoN) on 7/24/14 at 4:05 p.m., the DoN indicated the facility had identified multiple resident assessments</p>	R000217	<p>R 217 – Evaluation - Deficiency</p> <p>1, 2, and 3. In addition to the corrective action noted in R 214 above, the DON shall create a current resident list and review to insure, a complete and current service plan reflecting the resident needs and references of the assessment and evaluation.</p> <p>The DON shall be responsible to review and complete a clinical record audit of all residents weekly for 4 weeks, then every other week for 8 weeks, then monthly for 3 months to insure resident service plans are current and accurate to the specific health care needs of each resident.</p> <p>4. The Executive Director shall review the service plan audits and</p>		09/15/2014		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 07/28/2014	
NAME OF PROVIDER OR SUPPLIER COUNTRY CHARM VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 7212 US HWY 31 S INDIANAPOLIS, IN 46227			
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	<p>and evaluations which had not been completed in a timely manner. The DoN indicated she was in the process of completing evaluations for all of the residents, and as the evaluations were completed she was completing the service plans.</p> <p>2. The clinical record of Resident #C was reviewed on 7/25/14 at 9:20 a.m. Diagnoses included, but were not limited to, congestive heart failure, high blood pressure, diabetes, and depression.</p> <p>Resident #C had a service plan developed on 2/13/13. As of 7/28/14, a re-evaluation of the needs of Resident #C had not been completed and an updated service plan had not been developed.</p> <p>During an interview with the Director of Nursing (DoN) on 7/24/14 at 4:05 p.m., the DoN indicated the facility had identified multiple resident assessments and evaluations which had not been completed in a timely manner. The DoN indicated she was in the process of completing evaluations for all of the residents, and as the evaluations were completed she was completing the service plans.</p> <p>On 7/28/14 at 2:30 p.m., the DoN indicated the service plan for Resident #C</p>			<p>make report to the Quality Assurance Committee on the status of the timely completion of service plans.</p> <p>5. The date the systemic changes will be completed by September 15, 2014</p>			

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	<p>had not been updated since 2/13/13.</p> <p>3. Resident #50's clinical record was reviewed on 7/23/2014 at 1:00 p.m. Diagnoses included, but were not limited to, dementia (mental disorder affecting memory, personality, and reasoning), hypertension (high blood pressure), and anorexia (loss of appetite).</p> <p>Assessment and Service Plan for Indiana Assisted Living Facility for Resident #50 was completed on 3/15/2013.</p> <p>No documentation was found indicating a service plan had been completed for Resident #50, since 3/15/2013.</p> <p>On 7/24/2014 at 10:51 a.m., the Director of Nursing (DoN) indicated, she was unable to locate a service plan completed for Resident #50, since 3/15/2013.</p> <p>4. Resident #61's clinical record was reviewed on 7/23/2014 at 2:30 p.m. Diagnoses included, but were not limited to, dementia (mental disorder affecting memory, personality, and reasoning), diabetes (disorder causing irregular blood sugars), and hypertension (high blood pressure).</p> <p>Assessment and Service Plan for Indiana Assisted Living Facility for Resident #61</p>						

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	<p>was completed on 9/5/2013.</p> <p>No documentation was found indicating a service plan had been completed for Resident #61, since 9/5/2013.</p> <p>On 7/28/2014 at 11:40 a.m., the DoN indicated, she was unable to locate a service plan completed for Resident #61, since 9/5/2013.</p> <p>5. Resident #60's clinical record was reviewed on 7/24/2014 at 9:10 a.m. Diagnoses included, but were not limited to, hypertension (high blood pressure), end stage renal failure (kidney failure), and anemia (low red blood cell count).</p> <p>Assessment and Service Plan for Indiana Assisted Living Facility for Resident #60 was completed on 9/12/2013.</p> <p>No documentation was found indicating a service plan had been completed for Resident #60, since 9/12/2013.</p> <p>On 7/24/2014 at 1:45 p.m., the DoN indicated, she was unable to locate a service plan completed for Resident #60, since 9/12/2013.</p> <p>6. Resident #46's clinical record was reviewed on 7/24/2014 at 11:30 a.m. Diagnoses included, but were not limited</p>						

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	<p>to, dementia (mental disorder affecting memory, personality, and reasoning), hypertension (high blood pressure), and Crohn's disease (inflammatory bowel disease).</p> <p>Assessment and Service Plan for Indiana Assisted Living Facility for Resident #46 was completed on 3/25/2013.</p> <p>No documentation was found indicating a service plan had been completed for Resident #46, since 3/25/2013.</p> <p>On 7/28/2014 at 9:15 a.m., the DoN indicated, she was unable to locate a service plan completed for Resident #46, since 3/25/2013.</p> <p>7. Resident #A's clinical record was reviewed on 7/24/2014 at 2:00 p.m. Diagnoses included, but were not limited to, cerebrovascular accident (blood flow stopped to the brain, causing brain cell death) with left sided hemiparesis (muscle weakness on one side of the body), hypertension (high blood pressure) and urge incontinence (strong sudden need to urinate due to bladder spasms).</p> <p>Assessment and Service Plan for Indiana Assisted Living Facility for Resident #A was completed on 4/25/2013.</p>						

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	<p>No documentation was found indicating a service plan had been completed for Resident #A, since 4/25/2013.</p> <p>On 7/28/2014 at 9:15 a.m., the DoN indicated, she was unable to locate a service plan completed for Resident #A, since 4/25/2013.</p> <p>8. Resident #18's clinical record was reviewed on 7/25/2014 at 1:20 p.m. Diagnoses included, but were not limited to, hypertension (high blood pressure), cerebrovascular accident (blood flow to the brain is stopped causing brain cell death), and pernicious anemia (decrease in red blood cells caused by abnormal absorption of vitamin B12).</p> <p>No documentation was found indicating a service plan had been completed for Resident #18, since admission.</p> <p>On 7/28/2014 at 9:15 a.m., the DoN indicated, she was unable to locate a service plan for Resident #18.</p> <p>On 7/23/2014 at 5:00 p.m., the DoN indicated, the facility's policy is to complete an evaluation and service plan every three months.</p> <p>On 7/28/2014 at 9:00 a.m., the DoN provided an untitled section from Health</p>						

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R000273	<p>Related Service Ops Manual, undated, and indicated the policy was currently used by the facility. The policy indicated, "... Service Planning and Coordination -Initial Resident assessments performed before move-in, in consultation with the Wellness Director as needed -Coordination of service planning process upon move-in, 30 day review post move-in and every 90 days thereafter or as significant changes occur ..."</p> <p>On 7/28/2014 at 9:00 a.m., the DoN provided Resident Service Plan policy, undated, and indicated the policy was the one currently used by the facility. The policy indicated, "Following completion of an evaluation for each resident, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility."</p> <p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.</p>						

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	<p>Based on observation and interview, the facility failed to assure 9 of 9 residents residing on the secure unit who ate food prepared in kitchen, received food distributed and served under sanitary conditions.</p> <p>Findings include:</p> <p>During the service of noon meal on 07-24-14 at 11:05 a.m., with the following observed:</p> <p>The Dietary Manager was observed preparing deserts for the secured unit and placed the deserts on a cart. Dietary Staff #6 was observed transporting the uncovered deserts on the cart down a corridor of resident rooms. The deserts were delivered and given to the residents in the unit.</p> <p>Interview with Dietary Manager at 11: 50 a.m., indicated the cart of deserts should not have left the kitchen uncovered. She indicated, "The staff was taught at time of hire and inservices, anything leaving the kitchen would be covered. It is my expectation to cover anything leaving the kitchen."</p>		R000273	<p>R 273 – Food and Nutritional Services - Deficiency</p> <p>1. The alleged residents not receiving food in a sanitary manner has been corrected as described below.</p> <p>2. Because all residents can be affected by this alleged deficiency, the Executive Director had the Dietary Manager immediately review and also will have him/her attend a current ServeSafe food and sanitation certificate program to insure food preparation, food serving, and food serving areas are maintained in accordance with state and local sanitation and safe food handling standards.</p> <p>3. The dietary manager shall in-service all dietary staff on safe food handling techniques, procedures and process for transporting resident food from the kitchen, dietary area to the resident eating and serving areas. All management, including the Executive Director, and all members of the quality assurance committee, will attend this training in case they must serve residents or work in the kitchen during an</p>		09/15/2014	

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R000298	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency			<p>emergency.</p> <p>The Executive Director shall request from the facilities primary food supplier a list of dietary, food preparation, food serving, and handling topics to be created as a part of the dietary in-service program. The Executive Director shall instruct the facility dietician to monitor and review such techniques and concerns on a quarterly basis, and review such findings with the Executive Director.</p> <p>4. The Executive Director and all managers will rotate and observe meals on all shifts three times weekly for the next three months. Thereafter, all managers shall observe through assigned rotation meals twice monthly. Observation reports shall be presented to the Quality Assurance Committee at their first and second quarterly meeting.</p> <p>5. The date the systemic changes will be completed by September 15, 2014.</p>			

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	<p>(2) A consultant pharmacist shall be employed, or under contract, and shall:</p> <p>(A) be responsible for the duties as specified in 856 IAC 1-7;</p> <p>(B) review the drug handling and storage practices in the facility;</p> <p>(C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping;</p> <p>(D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and</p> <p>(E) review the drug regimen of each resident receiving these services at least once every sixty (60) days.</p> <p>Based on observation, interview, and record review, the facility failed to document the reconciliation of narcotic medications in 4 of 4 medication carts and failed to ensure medication carts remained clean for 2 of 4 medication carts reviewed for medication storage. (Cart #1, Cart #2, Cart #3, and Memory Care Cart)</p> <p>Findings include:</p> <p>1. During a review of the medication carts on 7/25/2014 from 11:20 a.m. to 12:30 p.m., the narcotic count sheets for July 2014, lacked signatures for multiple shifts, indicating narcotic counts were not completed.</p> <p>a. Cart #1 lacked signatures for 2 shifts on 7/2 and 7/3/14, and lacked signatures</p>	R000298	<p>R 298 – Pharmaceutical Services - Deficiency</p> <p>1. The corrective action as to Carts 1, 2, and 3, as well as the Memory Care Cart are described below.</p> <p>2 and 3. This alleged deficiency can affect all residents and the corrective action includes contracting with a consultant pharmacist who will review the drug handling and storage practices in the facility; provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs. This includes methods of management, recording, and monitoring scheduled narcotic</p>		09/15/2014		

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	<p>on 7/4, 7/5, 7/6, 7/18, and lacked 4 of the 6 signatures on 7/19/14. Signatures were missing on 7/22, 7/23, 7/24, and 7/25/14. The missing signatures on 7/19/14, indicated the narcotic count was not completed for 3 consecutive shifts.</p> <p>b. Cart #2 lacked signatures on 7/2, 7/3, 7/7, 7/16, 7/18, 7/19, 7/20, and 7/23/14. On 7/19/14, 3 of the 6 signatures were missing.</p> <p>c. Cart #3 lacked signatures on 7/2, 7/9, 7/18, 7/19, 7/20, 7/24, and 7/25. On 7/19/14, 4 of the 6 signatures were missing. The missing signatures on 7/19/14, indicated the narcotic count was not completed for 3 consecutive shifts.</p> <p>Memory Care Cart lacked signatures on 7/1, 7/2, 7/2, 7/10, 7/11, 7/12, 7/13, 7/16, 7/18, 7/19, 7/20, 7/23, and 7/24/14.</p> <p>During an interview with the Director of Nursing (DoN) on 7/25/14 at 11:30 a.m., the DoN indicated the nurses coming on shift count narcotics and sign and the nurses going off shift sign to verify the narcotic count.</p> <p>On 7/28/14 at 9:00 a.m., the DoN provided an undated policy, "Narcotic/Controlled Drugs" and indicated the policy was the one currently</p>		<p>drugs. The pharmacist consultant shall report in writing to the Executive Director any irregularities in dispensing, documentation, or the administering of drugs, and review the drug regimen of each resident receiving these services at least once every 60 days.</p> <p>The Consulting Pharmacist and the DON shall in-service, instruct, and educate the nursing staff on the complete use of the daily narcotic count sheets. The DON shall be responsible for completing narcotic count medication sheet audits of all residents with narcotic use weekly for 4 weeks, then every other week for 8 weeks, then monthly for 3 months. The narcotic count sheet audits shall be reviewed with the pharmacy consultant summary reports of every 60 days. The DON and pharmacy consultant shall meet and review findings, and other associated details with the Executive Director.</p> <p>The DON and Pharmacy consultant shall complete a schedule and listing for cleaning out the medication carts. The DON shall create and assign the nursing schedule to review and monitor with each shift</p>				

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	<p>used by the facility. The policy indicated, "...7. At each shift change, the narcotics count should be verified by the oncoming and previous shift. Each narcotic sheet should be verified with the actual count of the medications; the narcotic sheet should be signed by both the oncoming and previous shift Employee Partners...."</p> <p>2. On 7/25/2014 from 11:20 a.m. to 12:30 p.m., medication cart #1 and medication cart #2 were observed to have multiple stray pills in the bottom of each drawer.</p> <p>a. Medication cart #1 had five tablets, two half tablets, one capsule, and one gel cap scattered throughout the bottom of the drawers.</p> <p>b. Medication cart #2 had eight tablets, two half tablets, one gel cap, and one whole capsule scattered throughout the bottom of the drawers. In the bottom of one drawer, a broken capsule was found, with the powder contents spilt all over the backside of the drawer.</p> <p>On 7/25/2014 at 12:15 p.m., the Director of Nursing (DoN) indicated, the drawers are not suppose to have stray pills in them. There is not a set schedule to clean out the medication carts, but the night nurse is in charge of looking at the medication carts and reordering</p>		<p>assignment. The Pharmacist consultant shall review further with the 60 day summary, and report findings in summary report to the DON and Executive Director.</p> <p>The DON shall in-service and create a schedule for the medication carts to be maintained in a clean, neat and locked stationary area.</p> <p>4. The DON shall monitor daily for compliance. The Executive Director shall monitor weekly for three months. The Regional Manager shall monitor quarterly for compliance with this corrective action.</p> <p>5. This corrective action shall be completed by September 15, 2014.</p>				

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R000302	<p>medications. She continued to indicate, the facility would add the duty of cleaning out the medication carts to the night nurse job duties.</p> <p>On 7/25/2014 at 5:20 p.m., the DoN indicated, the facility's contracted pharmacy does come out to audit the medication carts, but she was not sure how often they come out.</p> <p>On 7/28/2014 at 9:00 a.m., the DoN provided the Storage of Medication policy, undated, and indicated the policy was the one currently used by the facility. The policy indicated, "1. All medications stored by the Community must be maintained in a clean, neat, LOCKED stationary container or area...."</p> <p>410 IAC 16.2-5-6(c)(6) Pharmaceutical Services - Deficiency (6) Over-the-counter medications must be identified with the following: (A) Resident name. (B) Physician name. (C) Expiration date. (D) Name of drug. (E) Strength. Based on observation, interview, and record review, the facility failed to ensure resident's over the counter medications</p>		R000302	R 302 – Pharmaceutical Services - Deficiency		09/15/2014	

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	<p>were labeled correctly in 3 of the 4 facility medication carts observed in that eleven medication bottles were found with only resident name and manufacturer labels.</p> <p>Findings include:</p> <p>On 7/25/2014 from 11:30 a.m. to 12:10 p.m., the facility's medication carts were observed to have eleven bottles with only the manufacturer's information and the resident's name.</p> <p>1. Cart #1 had Resident #5's calcium bottle labeled with the resident's name and manufacturer's label. Resident #44's Tylenol bottle was only labeled with the resident's name and manufacture's label. Resident #28's aspirin bottle was labeled with only resident's name and manufacturer's label.</p> <p>2. Cart #2 had Resident #8's aspirin bottle with only the manufacturer's label on it.</p> <p>3. Cart #3 had Resident #22's fish oil bottle labeled with the resident's name and manufacturer's label. Resident #7's multi-vitamin bottle was only labeled with the resident's name and manufacturer's label. Resident #26's Zantac, vitamin D-3, aspirin, Tylenol, and stool softener bottles were only</p>		<p>1. The corrective action as to three out of the four medication carts is described below.</p> <p>2 and 3. Over the counter medications, prescription drugs, vitamins, and biologicals used by the residents in the facility are labeled in accordance with currently accepted professional standards and principles including appropriate accessory and cautionary instructions and expiration dates. Resident over the counter medications are labeled with the resident name, apartment number, stored and administered with physician orders, including the date the OTC came into use by the resident.</p> <p>The DON shall in-service all nursing staff regarding the facility policy relating to over the counter medications, resident participation and facility protocols for administering. The DON shall complete a list of all residents using OTC medications and complete an OTC medication audit of those affected residents weekly for 4 weeks, then every other week for 8 weeks, then monthly for 3 months.</p>				

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R000349	<p>labeled with the resident's name and manufacturer's label.</p> <p>On 7/25/2014 at 12:15 p.m., the Director of Nursing (DoN) indicated, over the counter medication bottles kept in the medication carts, should be labeled with the resident's name, the resident's room number, and the physician's name. The eleven bottles shown to her were labeled incorrectly. She continued to indicate, the staff who are there when the medication bottles came in are responsible for labeling the bottles.</p> <p>On 7/28/2014 at 9:00 a.m., the DoN provided the Storage of Medications policy, undated, and indicated the policy was the one currently used by the facility. The policy indicated, "... 6. If a Resident has his/her over-the-counter (OTC) medications stored in the medication room, each OTC medication must be labeled with the Resident's name, unit number and date the medication was opened."</p> <p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as</p>			<p>The DON shall include over the medications, the monitoring and administering thereof in the yearly nursing in-service schedule for further compliance.</p> <p>4. The Pharmacy consultant shall review the monthly OTC resident log to review for interaction with other resident medications and treatments. The DON shall monitor daily for compliance. The Executive Director shall monitor weekly for three months. The Regional Manager shall monitor quarterly for compliance with this corrective action.</p> <p>5. This corrective action shall be completed by September 15, 2014.</p>			

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	<p>follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on interview and record review, the facility failed to ensure clinical records contained accurate and complete documentation regarding residents' code status (Residents #50, #60, #46, and #A), insulin administration (Resident #C), and activity and nursing progress notes (Resident #B and #C) for 6 of 8 resident records reviewed for complete and accurate documentation.</p> <p>Findings include:</p> <p>1a. Resident #50's clinical record was reviewed on 7/23/2014 at 1:00 p.m. Diagnoses included, but were not limited to, dementia (mental disorder affecting memory, personality, and reasoning), hypertension (high blood pressure), and anorexia (loss of appetite).</p> <p>Physician orders dated 3/28/2012, indicated Resident #50 was to be a full code.</p> <p>State of Indiana Out of Hospital Do Not Resuscitate Declaration and Order was signed and dated 9/12/2013, by Resident #50's Power of Attorney (POA).</p>	R000349	<p>R 349 – Clinical Records - Noncompliance</p> <p>1. The correction action for the Residents identified in the alleged deficiency accomplished is as follows:</p> <p>a. Resident 50 <i>Resident Code Status</i> was reviewed and verified with the Resident and/or Responsible Party. The Resident and physician signed off on the desired code status. The record is consistent with the Resident's wishes.</p> <p>b. Resident 60 is no longer a resident of the community.</p> <p>c. Resident 46 Resident Code Status was review and verified with the Resident and/or Responsible Party. The Resident and Physician signed off on the desired code status. The record is consistent with the Resident's wishes.</p> <p>d. Resident A Resident Code Status was reviewed and verified with the Resident and/or Responsible Party. The Resident</p>		09/15/2014		

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	<p>Country Charm Village Cardio-Pulmonary Resuscitation Directive dated 1/21/2013, indicated Resident #50 would like cardiopulmonary resuscitation (CPR) performed in an emergency.</p> <p>Country Charm Village Resident Emergency Information Sheet, undated, indicated Resident #50 would like CPR performed in an emergency.</p> <p>Assessment and Service Plan dated 3/15/2013, indicated Resident #50 would like CPR performed in an emergency.</p> <p>On 7/25/2014 at 9:00 a.m., the Director of Nursing (DoN) indicated, she talked to resident #50's POA and Resident #50 should be a do not resuscitate (DNR).</p> <p>In review of Resident #50's chart many inconsistencies were found regarding her code status.</p> <p>1b. Resident #60's closed clinical record was reviewed on 7/24/2014 at 9:10 a.m. Diagnoses included, but were not limited to, hypertension (high blood pressure), end stage renal failure (kidney failure), and anemia (low red blood cell count).</p> <p>Physician orders dated 9/12/2013, indicated Resident #60 was to be a</p>				<p>and Physician signed off on the desired code status. The record is consistent with the Resident's wishes.</p> <p>e. Resident B The nursing staff has been in-serviced regarding clinical nursing charting and all nursing shall use complete date and time in a legible and factual manner, with signature of writer for each entry in the resident's chart.</p> <p>f. Resident C The nursing staff has been in-services regarding clinical nursing charting and forms. The diabetic flow sheet has been included with the residents chart for accurate CBG monitoring. Nursing shall use complete date and time in a legible and factual manner, with signature of writer for each entry in the resident's chart.</p> <p>2. This deficiency may affect all residents. The DON shall perform a complete chart audit to review residents' code status, insulin administration, and nursing charting of progress and other notes. The DON shall review any identified resident code status with the facility resident emergency information sheet. Questions of accuracy shall be identified and discussed with the</p>		

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	<p>****full code *** unless otherwise stated by advance directive."</p> <p>Physician orders dated 9/12/2013, indicated Resident #60 was a no code.</p> <p>State of Indiana Out of Hospital Do Not Resuscitate Declaration and Order was signed and dated 10/15/2012, by Resident #60.</p> <p>Country Charm Village Cardio-Pulmonary Resuscitation Directive dated 1/15/2013, indicated Resident #60 would like cardiopulmonary resuscitation (CPR) performed in an emergency.</p> <p>Country Charm Village Resident Emergency Information Sheet, undated, indicated Resident #60 would like to be a DNR.</p> <p>Assessment and Service Plan dated 9/12/2013, indicated Resident #60 would like to be a DNR.</p> <p>On 7/24/2014 at 1:45 p.m., the DoN indicated, Resident #60 is no longer a resident at the facility. She would not be able to find out what code status he was suppose to be.</p> <p>In review of Resident #60's chart many</p>				<p>resident, the residents' family and physician.</p> <p>The DON shall review each resident chart to determine the status of advance directives determination and appropriate documentation. The DON shall work with the resident and their families to identify, list, and document accurately those listed desires.</p> <p>3. To ensure this deficiency does not recur, the DON shall create and monitor a specific resident listing identifying those residents who have a specific code status, that shall reviewed and monitored on quarterly basis when assessments and service plans are reviewed and updated.</p> <p>The DON shall in-service all nursing staff regarding current and appropriate clinical charting and methods, including charting thinning, entering lab and physician orders, and best practice use of the sections of the resident chart.</p> <p>The DON shall in-service all nursing staff regarding diabetic</p>		

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	<p>inconsistencies were found regarding his code status.</p> <p>1c. Resident #46's clinical record was reviewed on 7/24/2014 at 11:30 a.m. Diagnoses included, but were not limited to, dementia (mental disorder affecting memory, personality, and reasoning), hypertension (high blood pressure), and Crohn's disease (inflammatory bowel disease).</p> <p>Physician orders dated 12/26/2013, indicated Resident #46 was to be a "****full code *** unless otherwise stated by advance directive."</p> <p>Out of Hospital Do Not Resuscitate Declaration and Order was signed and dated 11/10/2010, by Resident #46.</p> <p>Country Charm Village Cardio-Pulmonary Resuscitation Directive dated 4/4/2013, indicated Resident #46 would like to be a DNR in the case of an emergency.</p> <p>Country Charm Village Resident Emergency Information Sheet, undated, indicated Resident #46 would like to be a DNR.</p> <p>Assessment and Service Plan dated 3/25/2013, indicated Resident #46 would</p>			<p>resident monitoring, including the use of diabetic flow sheets, signing and documenting the administering of the sliding scale insulin, dates, times, and accurately recording the capillary blood glucose reading form.</p> <p>The DON shall be responsible for completing audits of all service plans for residents receiving diabetic monitoring weekly for 4 weeks, then every other week for 8 weeks, then monthly for 3 months. Results shall be reported to the QA committee and Executive Director for review and further corrective actions as deemed necessary.</p> <p>4. The Executive Director shall monitor weekly for six months and the Regional Manager shall monitor the Executive Director for compliance quarterly.</p> <p>5. This corrective action shall be completed by September 15, 2014</p>			

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	<p>like to be a DNR.</p> <p>On 7/25/2014 at 9:00 a.m., the DoN indicated, Resident #46 is suppose to be a DNR in an emergency situation.</p> <p>In review of Resident #46's chart many inconsistencies were found regarding his code status.</p> <p>1d. Resident #A's clinical record was reviewed on 7/24/2014 at 2:00 p.m. Diagnoses included, but were not limited to, cerebrovascular accident (blood flow stopped to the brain, causing brain cell death) with left sided hemiparesis (muscle weakness on one side of the body), hypertension (high blood pressure) and urge incontinence (strong sudden need to urinate due to bladder spasms).</p> <p>Physician orders dated 5/30/2012, indicated Resident #A was to be a DNR.</p> <p>Country Charm Village Cardio-Pulmonary Resuscitation Directive dated 8/25/2012, indicated Resident #A would like cardiopulmonary resuscitation (CPR) preformed in an emergency.</p> <p>Country Charm Village Resident Emergency Information Sheet, undated, indicated Resident #A would like to have</p>						

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	<p>CPR in an emergency situation.</p> <p>On 7/25/2014 at 9:00 a.m., the DoN indicated, Resident #A would like to have CPR performed in the case of an emergency.</p> <p>In review of Resident #A's chart many inconsistencies were found regarding his code status.</p> <p>On 7/25/2014 at 9:00 a.m., the DoN indicated it is facility policy to use the information on the Country Charm Village Cardio-Pulmonary Resuscitation Directive sheet in case of an emergency. She was not sure why the clinical records had inconsistent documentation regarding code status. She continued to indicate, the charts may have not been updated when code status preferences had been changed.</p> <p>On 7/28/2014 at 9:00 a.m., the DoN provided Advanced Directive: Do Not Resuscitate (DNR), undated, and indicated the policy was the one currently used by the facility. The policy indicated, "... 6. The Director of Health Services or designee is responsible for conducting annual review of all advanced directive orders, and ensuring that all qualified staff are aware of the resident's wished regarding resuscitation."</p>						

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	<p>On 7/28/2014 at 9:00 a.m., the DoN provided Clinical Records, undated, and indicated the policy was the one currently used by the facility. The policy indicated, "The facility must maintain clinical records on each resident.... The records must be complete, accurately documented, readily accessible, and systematically organized...."</p> <p>2. The clinical record of Resident #C was reviewed on 7/25/14 at 9:20 a.m. Diagnoses included, but were not limited to, congestive heart failure, high blood pressure, diabetes, and depression.</p> <p>A recapitulated of the physician's orders for June 2014, indicated Resident #C was to have Accucheck before meals and daily at bedtime, and was to receive a sliding scale insulin according to the Accucheck. The origination date of the physician's order for sliding scale and Accucheck was 11/15/13. Resident #C also had a physician's order to receive NovoLog (a short acting insulin) 5 units at mealtimes with the sliding scale dose. The origination date of the physician's order for 5 units with meals was 3/9/14. The physician's orders lacked call parameters (high or low) for the blood sugars.</p>						

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	<p>During a review of the Diabetic Flow Sheets for May, June, and July 2014, the documentation of the sliding scale insulin administration was illegible and incomplete. The flowsheets lacked documentation of name or initials of staff members administering the sliding scale insulin. The flowsheet for July 2014, lacked documentation of sliding scale insulin administration at bedtime for 7/15-7/25/14. The Accucheck results at bedtime for those dates indicated Resident #C should have received sliding scale insulin on 7/15, 7/17, 7/18, 7/19, 7/20, 7/22, 7/23, and 7/24/14.</p> <p>During an interview with the Director of Nursing (DoN) on 7/25/14 at 12:15 p.m., the DoN indicated the documentation of the blood sugar results and administration of the sliding scale insulin on the Diabetic Flowsheets was difficult to read and accurately determine how much insulin the resident had received each day. The DoN indicated the initials of the nurse administering the dose, the site of the administration, as well as the amount administered should have been legible on the flowsheets.</p> <p>On 7/28/14 at 9:00 a.m., the DoN provided Diabetic Resident Monitoring, dated 06/08, and indicated the policy was the one currently used by the facility.</p>						

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	<p>The procedure section of the policy indicated, "...1. All diabetic residents with physicians' orders for capillary blood glucose (CBG) monitoring will have low and high parameters for physician notification included with the CBG order...9. Routine and random CBG levels for each resident will be recorded on the Capillary Blood Glucose Readings Form. Insulin coverage amounts will also be recorded on this form...."</p> <p>3a. The clinical record of Resident #C was reviewed on 7/25/14 at 9:20 a.m. Diagnoses included, but were not limited to, congestive heart failure, high blood pressure, diabetes, and depression.</p> <p>The nursing progress notes for May, June, and July 2014 for Resident #C lacked documentation of the time of the entry and complete dates for multiple entries in the record. The time was recorded as "Days" or "Evenings" or was missing. Dates were recorded as the month and day but lacked the year of the entry.</p> <p>During an interview with the Director of Nursing (DoN) on 7/24/14 at 4:05 p.m., the DoN indicated the staff should use a complete date and time of each entry in the record.</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	<p>On 7/28/14 at 2:40 p.m., the DoN provided an undated policy titled "Documentation of Assistance" and indicated the policy was the one currently used by the facility. The policy indicated, "...5...date and times should be listed and accurate, legible and factual documentation should be the only entries made here...."</p> <p>3b. The clinical record of Resident #B was reviewed on 7/23/14 at 1:05 p.m. Resident #B was admitted to the facility on 5/31/13. Diagnoses included, but were not limited to, hypertension, Alzheimer's disease, depression, and blindness in the left eye.</p> <p>During a review of the clinical record, the nursing progress notes, activity progress notes, and dietary progress notes lacked completed date and time of entries. The nursing progress notes had times recorded as "Days" or "Evenings" or the time was missing. Some dates were recorded as the month and day but lacked the year of the entry. The activity progress notes lacked complete dates and lacked times of entry. Each date entered was recorded as the month and year, such a 6/14, and lacked a time indication. The dietary progress notes contained complete dates, but lacked a time indication for each entry.</p>						

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R000352	<p>During an interview with the Director of Nursing (DoN) on 7/24/14 at 4:05 p.m., the DoN indicated the staff should use a complete date and time of each entry in the record.</p> <p>On 7/28/14 at 2:40 p.m., the DoN provided an undated policy titled "Documentation of Assistance" and indicated the policy was the one currently used by the facility. The policy indicated, "...5...date and times should be listed and accurate, legible and factual documentation should be the only entries made here...."</p> <p>410 IAC 16.2-5-8.1(e)(1-4) Clinical Records - Noncompliance (e) The clinical record must contain the following: (1) Sufficient information to identify the resident. (2) A record of the resident 's evaluations. (3) Services provided. (4) Progress notes.</p> <p>Based on record review and interview, the facility lacked documentation of services provided to a resident who required assistance with stockings as ordered by the physician and failed to ensure a catheter was flushed 2 times per week for 1 of 8 residents reviewed. (Resident #C)</p>		R000352	<p>R 352 – Clinical Records - Noncompliance 1. The corrective action for Resident C to have his/her catheter flushed twice and to train all appropriate staff that this must be done. It is also in the service plan. 2 and 3. The DON shall be responsible for completing an observational resident chart audit to list and identify resident specific physician and treatment orders. This shall</p>		09/15/2014	

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	<p>Findings include:</p> <p>The clinical record of Resident #C was reviewed on 7/25/14 at 9:20 a.m. Diagnoses included, but were not limited to, congestive heart failure, high blood pressure, diabetes, and depression.</p> <p>1. A recapitulated of the physician's orders for June 2014, with an origination date of 3/18/14, indicated Resident #C was to have T.E.D. hose (thromboembolism-deterrent hose) applied every morning and removed at bedtime for edema.</p> <p>During a review of the Treatment Flow Sheets for May, June, and July 2014, the documentation of the knee high T.E.D. hose application and removal was blank, indicating the hose were not applied and removed as ordered.</p> <p>The nursing progress notes from April 2014 through July 2014 for Resident #C lacked documentation of the resident having or refusing to wear the T.E.D. hose.</p> <p>During an interview with the Director of Nursing (DoN) on 7/25/14 at 12:15 p.m., the DoN indicated Resident #C was not always compliant with the T.E.D. hose and the staff should have indicated on the</p>		<p>include specific treatment flow sheets. The DON shall audit and insure all treatment flow sheets are identified and referenced within the residents' service plan to insure timeliness and completeness. The DON shall in-service all nursing staff with the appropriate charting methods for treatment flow sheets, physician orders, and coordination of other services with outside providers. The DON shall be responsible for completing and observational nursing shadowing regime to observe, teach, and educate with best practices to the treatment flow sheet activity. The DON shall be responsible for continuing such nursing treatment observations with the nursing staff by witnessing and observing treatments weekly for 4 weeks, then every other week for 8 weeks, then monthly for 3 months. Results shall be reported to the QA team, the Executive Director, and the residents' primary care physician as needed. 4. The Executive Director shall monitor weekly for six months. 5. This corrective action shall be completed by September 15, 2014.</p>				

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	<p>sheets when the hose were refused. The DoN indicated the staff should have documented on the Treatment Flow Sheet as well as in the communication book to alert the nurses to the refusal by the resident.</p> <p>2. A recapitulated of the physician's orders for June 2014, indicated Resident #C was to have catheter irrigations twice weekly via Home Health. The origination date of the irrigation order was 4/17/14.</p> <p>During a review of the Treatment Flow Sheets for May, June, and July 2014, the documentation of catheter irrigations was blank.</p> <p>The clinical record of Resident #C lacked documentation of services provided by Home Health.</p> <p>During an interview with the DoN on 7/25/14 at 12:15 p.m., the DoN indicated the catheter irrigations were completed by Home Health and not the facility staff. The DoN indicated the documentation of the visits by Home Health were maintained in a separate binder. The DoN provided a binder marked Home Health and indicated the records should be in the binder under the resident's name. No records were found for</p>						

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R000410	<p>Resident #C in the binder. The DoN indicated the Home Health staff report to the nurse when the visit is completed, but did not think the Home Health staff placed a note in the chart for each visit.</p> <p>The nursing progress notes from April 2014 through July 2014, for Resident #C lacked documentation of the resident receiving services from Home Health.</p> <p>On 7/28/14 at 9:00 a.m., the DoN provided an undated Third Party Care Providers policy, and indicated the policy was the one currently used by the facility. "...6...All medications and or treatments can only be done with proper physician orders and must be provided to the Community for Resident records. Documentation must be provided after each visit regarding care/assistance provided...."</p> <p>410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a</p>						

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	<p>documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>Based on interview and record review, the facility failed to ensure residents received screening for tuberculosis (lung disease) at admission and annually for 4 of 8 residents in that residents did not receive tuberculin skin tests (screening test of a lung disease called tuberculosis). (Residents #B, #18, #60, and #61)</p> <p>Findings include:</p> <p>1. Resident #18's clinical record was reviewed on 7/25/2014 at 1:20 p.m. Diagnoses included, but were not limited to, hypertension (high blood pressure), cerebrovascular accident (blood flow to the brain is stopped, causing brain cell death), and pernicious anemia (decrease in red blood cells caused by abnormal absorption of vitamin B12).</p> <p>Resident #18 was admitted 6/30/2014.</p>	R000410	<p>R 410 – Infection Control - Noncompliance</p> <p>1. The corrective action for residents B, 18, 60 and 61 that was accomplished was completed screening for tuberculin. 2. This alleged deficiency could affect all residents and the DON shall perform a resident audit to verify all residents are in compliance with their annual tuberculin test, and initiate a new test where needed. 3. To ensure that this alleged deficiency does not recur, the DON has developed, and implemented infection control policies and procedures to ensure controlled practices designed to provide a safe, sanitary and comfortable environment intended to help prevent the development and transmission of disease and infection. The DON shall in-service nursing staff regarding the resident admission assessment which includes the tuberculin skin test performance</p>		09/15/2014		

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	<p>Documentation from a previous residence dated 9/5/2013 at 3:30 p.m., indicated Resident #18 had received a tuberculin test.</p> <p>No documentation was found indicating Resident #18 received a tuberculin test three months prior to admission or upon admission to the facility.</p> <p>On 7/28/2014 at 9:00 a.m., the Director of Nursing (DoN) indicated, she was unable to locate documentation indicating Resident #18 had received a tuberculin test three months prior to admission or upon admission. She continued to indicate, Resident #18 had received the start of a tuberculin test this past weekend.</p> <p>2. Resident #61's clinical record was reviewed on 7/23/2014 at 2:30 p.m. Diagnoses included, but were not limited to, dementia (mental disorder affecting memory, personality and reasoning), diabetes (disorder causing irregular blood sugars), and hypertension (high blood pressure).</p> <p>No documentation was found indicating Resident #61 received an annual tuberculin test in 2013 or 2014.</p> <p>On 7/28/2014 at 11:40 a.m., the DoN</p>		<p>upon admission, and annual thereafter. The DON shall create and maintain a resident tuberculin test listing, identifying the annual renewal month for each resident requiring their annual tuberculin test, and shall review and monitor for compliance. 4. The Executive Director will audit monthly move-in to ensure the corrective action is occurring. 5. The date this corrective action shall be completed by is September 15, 2014.</p>				

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	<p>indicated, she was unable to locate any documentation indicating Resident #61 had received a tuberculin test in 2013 or 2014.</p> <p>3. Resident #60's clinical record was reviewed on 7/24/2014 at 9:10 a.m. Diagnoses included, but were not limited to, hypertension (high blood pressure), end stage renal failure (kidney failure), and anemia (low red blood cell count).</p> <p>No documentation was found indicating Resident #60 received an annual tuberculin test in 2013 or 2014.</p> <p>On 7/24/2014 at 1:45 p.m., the DoN indicated, she was unable to locate any documentation indicating Resident #60 had received a tuberculin test in 2013 or 2014. All residents receive a tuberculin test every October.</p> <p>4. The clinical record of Resident #B was reviewed on 7/23/14 at 1:05 p.m. Resident #B was admitted to the facility on 5/31/13. Diagnoses included, but were not limited to, hypertension, Alzheimer's disease, depression, and blindness in the left eye.</p> <p>The clinical record of Resident #B lacked documentation of tuberculosis (TB) screening within 3 months of admission</p>						

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	<p>and lacked documentation of screening upon admission 5/31/13.</p> <p>During an interview with the Director of Nursing (DoN) on 7/23/14, at 1:45 p.m., the DoN indicated the results of TB tests were kept in a separate binder and she was not able to find results for Resident #B. The DoN indicated Resident #B had a TB test at another facility on 1/21/13, but was not given a TB test upon admission to this facility.</p> <p>On 7/28/14 at 9:00 a.m., the DoN provided the policy Resident Screening-Communicable Disease Diagnostics, dated 12/2004, and indicated the policy was the one currently used by the facility. The procedure section of the policy indicated, "...3. All residents will have a tuberculin skin test accomplished through use of the Mantoux method (5TU PPD), administered at the time of admission, or within three (3) months prior to admission...11. The Tuberculosis Screening Record will be updated annually for each resident after administration of the one-step Mantoux test. The screening record will be maintained in the resident's clinical record permanently...."</p>						

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R000414	<p>410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>Based on observation, interview, and record review, the facility failed to ensure staff washed their hands between direct contact with residents for 1 of 5 observed medication passes in that the staff member did not wash her hands between residents. (Residents #44 and #32) (LPN #1)</p> <p>Findings include:</p> <p>On 7/25/2014 from 11:05 a.m. till 11:20 a.m., LPN #1 was observed administering medication to Resident #44. There was no observation made after this medication pass of LPN #1 washing her hands. LPN#1 then continued to look for Resident #32. Once LPN #1 found Resident #32, she administered his afternoon medication.</p> <p>On 7/25/2014 at 11:20 a.m., LPN #1 indicated, it is facility policy for staff to wash their hands after contact with residents. LPN #1 continued to indicate, she should have washed her hands between each resident's medication pass.</p> <p>On 7/25.2014 at 12:15 p.m., the Director</p>	R000414	<p>R 414 – Infection Control - Deficiency 1. The corrective action as it affected Residents 44 and 34 and LPN 1 that has been accomplished is that LPN 1 has been individually re-educated as to the infection control policy; specifically hand washing. The DON shall review, follow, and monitor LPN 1 for thirty days to ensure compliance. 2 and 3. Because this deficiency can affect all residents and threaten the health of employees, the DON shall create a new hand washing procedure and post where nursing staff can review as a reminder. The DON shall in-service the nursing staff on the specifics of the procedure which shall include the use of antibacterial soap, working up a lather on hands, wrists, and forearms, and cleansing nails and fingernails; rinsing hands, and wrists thoroughly with running water, before drying hands with paper towels, then disposing of towels in a covered garbage can. The DON and Executive Director shall utilize the same hand washing procedure as a part of the orientation of new employee hires. The DON and Executive Director shall post the hand washing procedures with each</p>		09/15/2014		

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	<p>of Nursing (DoN) indicated, the facility's policy is to sanitize between each resident. Staff can use the hand gel sanitizer two times, but needs to use soap and water the third time of washing their hands.</p> <p>On 7/23/2014 at 11:40 a.m., the Marketing Director provided the precautions - standard Policy, dated 2002, and indicated the policy was the one currently used by the facility. The policy indicated, "... All staff must wash their hands: a. Before and after any direct contact with resident...."</p>				<p>department, and shall monitor for compliance. The hand washing/ infection control will include all shifts seven days a week. The Licensed Nurse on duty for each shift shall monitor compliance.</p> <p>4. The Executive Director will audit monthly move-in to ensure the corrective action is occurring.</p> <p>5. The date this corrective action shall be completed by is September 15, 2014.</p>		